come experts in the ethics of resuscitation, I think it is our responsibility to understand its basic questions. We spend a lot of time in medical school and in continuing education learning when and how to work up and treat various presenting signs and symptoms. Should we not also discuss the indications for and against the use of resuscitation techniques?

Most medical schools, including my own, do instruct students in ethics, communication skills and the psychologies of grief and pain as part of our introduction to the "doctor-patient relationship." The problem is that when we hit the wards in our third and fourth years, these issues are largely ignored: the thoughtful and considerate psychiatrists and sociologists are gone, and the academic ward attending physicians, who are always rushing off to their labs or to one more surgery, don't have the time or will to discuss such matters. The final result is that these issues are not only ignored, but that this ignorance becomes transformed—first to indifference and then to avoidance.

I would like to propose a four-week course for fourth-year medical students that would replace part of the preclinical social science curriculum. The purpose of this course would be to review interviewing skills *after* students have interviewed for a year and know what the difficulties are; it would reinvestigate death and dying *after* students have cared for the terminally ill and understand what they and their families are experiencing; it would reexplore ethical issues such as a patient's right to know, the use of ventilators and other extraordinary means, and the determination of code status *after* students have seen these problems arise in real life; it would review the role of preventive medicine and patient education *after* students have examined the "pink puffers" and "blue bloaters," the malnourished and the abused. It does little good to address these issues theoretically if we do not also learn how to think about them and apply them clinically.

And we do need to apply them. In an age when most American physicians are equally competent—and equally expensive—in treating common medical problems, it is our understanding of the interpersonal art of medicine that will set us apart. The combination of greater public knowledge about health matters, severe malpractice suits and physician overpopulation makes it imperative that doctors pay more attention to the doctor-patient and doctor-family relationships. For our patients' benefits and for our own economic and personal integrity, we are going to have to learn to practice what we preach.

At the moment, all I can do is preach. Come July, however, I will start to practice, and I know that I won't be any more comfortable discussing DNR orders with my patients then than I am now. My hope is that experience will teach me how to conscientiously approach these issues, but I have a feeling that experience will only confirm bad habits. Establishing new habits will require new role models and new positive experiences. I think we should start now.

MARC TUNZI
University of California, San Diego, School of Medicine

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'Officialese' Versus Plain English

TO THE EDITOR: The special article by Stephen Lewis in the January issue on prospective pricing and DRGs[1] is one of the most important articles on the economics of medicine published in the journal in many years. The information is of interest to any practicing physician, in addition to hospital administrators. The history of DRGs and the way they are supposed to work will have a tremendous impact on the way we practice medicine over the next few years. Mr Lewis is to be complimented for his effort.

Unfortunately, Mr Lewis has chosen to write this article in the "official style," not plain English. As a result, it is almost unreadable. Any physician who has read this article in its entirety is either to be complimented or accused of being a masochist. Any physician who is able to understand the content had to translate the article. This is unfortunate. The prospective pricing system and DRGs are too important to be lost in the unnecessary, overly complex prose of "officialese." Mr Lewis would do us all a service if he rewrote the article in plain English. We all need the information he presented.

T. JAMES ROBNETT, MD, MBA
Upland, California

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1. Lewis S: Prospective pricing and DRGs. West J Med 1984 Jan; 140:123-128

EDITOR'S NOTE

Will this "officialese" not soon be common usage? It seems likely. MSMW